CASE MANAGEMENT WITH SPECIAL POPULATIONS: PEOPLE LABELLED MENTALLY RETARDED

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INTRODUCTION

Case management, an approach to service delivery, has been identified as a priority service through federal and state law. Although the definitions of this service are numerous, it has been viewed as a critical component of deinstitutionalization. An effective case management system is imperative for successful deinstitutionalization as it is the link between clients and support services in the community. The chances of success or failure of persons placed in the community are dependent as much on the appropriateness of the particular setting and what happens in that setting or placement of the client as they are to the characteristics of the individual. One important aspect of a mentally retarded person's environment is the manner in which services are provided, and a great deal of attention has been given to the need for coordination among community support services and community residential programs. Case management is instrumental in this coordination. Thus once the deinstitutionalization process occurs, success of a client may be contingent upon effective case management.

The study reported here focuses on the role and function of case managers providing services to mentally retarded individuals. It was designed to help explain, clarify and define case management practices in the Southeast Region of Pennsylvania. The complex nature of case management, as well as its differing priorities in agencies across the region, results in a lack of consistency in the role and function of case managers. Case management is a function which requires an integrative and holistic approach. Programs however, are frequently organized categorically as evidenced by service delivery systems for the mentally retarded.

The case manager is at the center of access to the service delivery system for deinstitutionalized individuals. With a greater number of mentally retarded persons becoming deinstitutionalized, the necessity for clarification of the role and function of case managers becomes more urgent.

CONTEXTUAL BACKGROUND:

It is estimated that some nine million persons (approximately 3% of the population of the United States) are developmentally disabled. The term developmentally disabled originates from a 1960's coalition of individuals and organizations that attempted to extend legislation to meet the service needs of the mentally retarded and other disabled groups. As originally conceived, the definition of developmental disabilities included cerebral palsy, epilepsy, mental retardation, and other neurologically handicapping conditions closely related to mental retardation. The definition in the 1978 extension of the Developmental Disabilities Act (P.L.95-602) does not use a diagnostic label. This reduces some of the stigma associated with labeling, but leaves some question with respect to constituency. For purposes of this study, the primary focus is on those persons who have been diagnosed mentally retarded.

To understand who is and who is not mentally retarded in any given system, attention must be directed to those who have legitimate and sanctioned authority to make such a judgement on behalf of the social system (Kurtz, 1977). An individual is considered to be mentally retarded on the basis of system-utilized standards. The application of these standards has changed over time; nevertheless, its impact has been felt by significant numbers of individuals.

Mental retardation is defined in terms of intellectual functioning, adaptive behavior and age at which original identification is made. The American Association on Mental Deficiency defines mental retardation as significantly sub-average general intellectural functioning existing concurrently with deficits in adaptive behavior and manifested before age 18. Significantly sub-average intellectual functioning means more than two standard deviations below normal on intelligence quotient tests (approximately 70 and below) (Grossman, 1977). Adaptive behavior is defined, "as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group" (Grossman, 1977).

Historically, mentally retarded persons, especially those with disabilities labeled as severe, have had limited access to community services. They were often placed in large congregate living arrangements remote from their home communities. For decades, the institution was the only clearly defined service for mentally retarded individuals. The present replacement of public residential facilities by various community based residential alternatives is one of the most remarkable social changes of the century, ranking with desegregation of the public schools, in its ideological and political impact (Novak and Heal, 1980).

Within the past two decades, there has been a nationwide shift in the philosophical tenets underlying services to persons with developmental disabilities. Along with the shift, there has been an accompanying emphasis placed upon diversification of service alternatives as opposed to centralized residential service systems. Many states have adopted the concept of a continuum of residential service, varying in restrictiveness, size, and formal regulatory focus. These changes in the structure and function of the service delivery system have been associated with deinstitutionalization and the Normalization Principle. The Normalization Principle (Nirje, 1969; Wolfensberger, 1972) suggests that mentally retarded individuals should be served in ways that are as normal as possible. From the Normalization Principle comes the practical reality of deinstitutionalization.

Begun in the late 1960's for those classified as mentally ill, the deinstitutionalization movement served as an impetus for change in the patterns of service delivery to the mentally retarded. Deinstitutionalization as a strategy for social change occurred within the context of other movements, including consumerism and civil rights. These political and social exigencies, in conjunction with public interest law and increased advocacy on behalf of mentally retarded individuals, served as a catalyst for change.

For decades, the institution had been viewed as the most viable service arrangement for mentally retarded individuals. Little attention had been focused on how alternatives in service might best be delivered to this diverse group of individuals. In the institution, as defined by Goffman (1969), the total life needs of an individual are met within the facility. The institutional setting becomes physically, socially, and psychologically predominant and all inclusive to the resident. Deinstitutionalization, however, required something different with respect to the delivery of services to the mentally retarded.

Deinstitutionalization represents fundamental social change. It is concerned with the basic social provision for a segment of society labeled mentally retarded. According to David Gil (1982), key issues of provision are: 1) choice of kinds of provisions, 2) modes of production, 3) modes of distribution, and 4) modes of decision-making. Issues revolving around social provision are very much interrelated with the needs of the mentally retarded, as in many instances it is necessary to arrange for the needs of some of these individuals over the full lifecycle continuum.

How a society approaches or attempts to arrange such social provisions is often a philosophical and political task. It can require strategies aimed at radical transformation of values, consciousness, and social institutions. The deinstitutionalization movement has been such a case in point. Deinstitutionalization has been accompanied by debate and confrontation. Opponents of this shift in orientation regarding the treatment and provision of service to the mentally retarded, suggest that deinstitutionalization is moving ahead much too rapidly. These individuals argue that the data doesn't warrant the wholesale abandonment of institutions (Baumeister, 1978; Begab, 1978; Balla, 1978; Ellis, et. al., Memorandum, 10-1978).

Massive efforts to deinstitutionalize residents of public institutions have led to the discharge of individuals who years ago would not have been considered 'appropriate' for discharge. Frequently, it has meant that those discharged were readmitted because community placement was deemed to be unsuccessful. Deinstitutionalization has meant change. It represents a dispersal of power. Likewise, it represents a shift in orientation from a centralized service system, the institution, to a decentralized service system, the community. As such it has the potential of straining the boundaries of the existing service delivery system. This is especially relevant when the philosophy which drives the change requires that the needs of the individual be considered regardless of program needs. Such a decentralized service system places greater demands on staff. The system needs well-trained professionals capable of straddling the boundaries established by the numerous categorically focused agencies. It is incumbent upon the service delivery system to assure that deinstitutionalization, as a predominant philosophy, be afforded the opportunity to work. Whether it works, will be representative of, "... the ability of: a) public facility personnel to prepare people for community life, b) social

service personnel to make appropriate placement decisions and c) community facility and agency personnel to adapt their programs to the specialized needs of former residents of public residential facilities" (Lakin, Hill, Hauber, Bruinicks, and Heal, 1983, p. 13). It is the latter issue with which this research effort is concerned. One such system's response has been the development of case management systems.

Case management has been experimented with by individuals working with the aged, child welfare and juvenile justice. Both federal and state legislation have designated case management as a priority service (P.L. 95-602, 1979 and The Pennsylvania Mental Health and Mental Retardation Act of 1966). The theoretical construct of case management was accepted by many as being a viable service delivery strategy and, as mentioned above, it is thought to be critical to the successful deinstitutionalization of the mentally retarded person. As the primary, or only, link between the client and the outside service system, the case manager is vital to the experiences of the client subsequent to deinstitutionalization. If the functioning of this vital link is not effective, the client's experiences could very likely prove to be discouraging and unsuccessful. The case manager is ultimately central to all community-based service delivery for the client and the importance of this role cannot be overemphasized.

An increase in communication and greater knowledge of what exists in the field is critical and urgent at this time when deinstitutionalization is increasing. This study was undertaken in order to determine the current state of case management as viewed by case managers themselves.

RESEARCH DESIGN:

The court ordered deinstitutionalization of the Pennhurst State School and Hospital for the mentally retarded located in Chester County, Pennsylvania served as the impetus for the investigation. While employed by the Office of the special Master, an office established to carry out the court ordered deinstituionalization of Pennhurst residents, it became apparent that much was dependent upon the community service system. It was the basic contention of this researcher that little was known about this system which was about to be required to provide case management services to individuals affected by the Court ordered change. It was also the belief of this researcher that the success of the deinstitutionalization process was contingent upon an effective operational service system, which could respond to the needs of those returning individuals.

METHODOLOGY:

A survey instrument was utilized to gather information from case managers regarding the services activities they engaged in; the work environment in which they performed these tasks, the educational and training needs they deemed to be important in the performance of case management, demographic characteristics of the population of case managers and their definition of case management. The instrument yielded a nine page questionnaire, incorporating 154 discrete items.

SOURCES OF DATA:

A population of 118 case managers in the five county area of the Southeast Region in Pennsylvania made up the subject pool for the study. There were 102 respondents, 86% of the population. The survey was conducted in the winter of 1982-83.

RESEARCH QUESTIONS:

Case managers were asked to respond to the following research questions:

1. What are the service activities in which case managers are engaged?
2. What activities should be a part of the case manager's job?
3. With what types of community resources do case managers have most contact, and are these contacts based on formal or informal linkages?
4. With whom do the case managers work?
5. In what type of management structure(s) do the case managers operate?
6. What is the work environment of the case manager?
7. How is the case manager's job designed, as seen by the case manager?
8. How should the case manager's job be designed?
9. What knowledge, skills, and abilities are necessary for the case manager?
10. Who are the case managers in the field of mental retardation in the Southeast Region of Pennsylvania?

ANALYSIS OF DATA

Several types of statistical and analytical methodologies have been employed in the interpretation of data derived from the survey of case managers.

At one level of analysis, descriptive techniques have been used. This is especially relevant in the development of the profile of case managers. Variables included are: age, sex, race and educational background. This information is presented in the aggregate to form the basis for the description of case managers in the Southeast region of Pennsylvania.

Further statistical analysis of the data attempted to contrast case management in the southeast region of several dimensions indentified in the survey. The independent variables selected identified the administrative structure in which the case managers worked, their educational background or major field, and the county in which they worked. For this purpose, factor analysis and non-parametric statistical methods have been employed.

The case managers perceptions of appropriateness of service activities yielded - means ($\bar{X}$) and standard deviations (SD) of all 23 service activities. Analysis of variance and post hoc analysis were conducted only on the major categories of 1) screening; 2) initial diagnosis and assessment; 3) service plan development; 4) agency contacts; 5) client contacts; 6) recording/reporting; and 7) evaluation of community service.

These service activities were identified as the dependent variables in these analyses.

The Work Environment Index was used to ascertain case managers' perception of the organizational context and interactive functions. The Work Environment Index is an instrument on which reliability and validity were conducted at the University of Texas (Carrogonne; 1980). Factors important in the performance of the case management function were identified. The same variables were measured by rating case managers' perceptions at two points - what exist now and what should exist. Factor analysis was conducted on the twenty-nine variables found in the Work Environment index. A final solution yielded three factors which included fourteen of the twenty-nine variables. Individual scores were found for the three factors. The three factors were indentified as being 1) creativity/flexibility; 2) rigidity/inflexibility; 3) ambiguity. These factors served as the dependent variables. In Post Hoc Analysis, repeated measures on Analysis of Variance were completed - this was followed by Simple Significant Effects and Newman-Kuels Pairwise Comparisons.

Finally, the importance of various knowledge, skills and abilities in the performance of case management was analyzed. Fifteen variables were included in the section of the questionnaire. A final solution yielded three factors which encompassed eleven of the original fifteen variables. The procedures utilized in the analysis of the Work Environment Index were repeated.

These analyses of the data were performed to further the understanding of case management and provide answers to the research questions outlined above.

The survey of case managers, has been concerned with the case managers and their perceptions of what they do, the environment in which they carry out those tasks, the knowledge base necessary to perform the tasks and a description of who the case managers are. The information elicited from the respondents falls into five basic categories. They are: A) service activities of case managers, B) organizational context of the case manager, C) the educational and training needs of the case managers, D) description of the case managers, and E) definition of case management.

At the time of the survey 118 individuals were identified as case managers. Of the 118, 86.4% (n=102) responded to the questionnaire.

SERVICE ACTIVITES:

Case managers were asked what service functions they performed and approximately how much time per week was spent in each activity. (see tables 1 and 2). The study showed that the majority of case managers are involved in activities related to service plan development, agency contact(s), client contact(s), recording and reporting, and evaluation of community services. While screening, initial diagnosis and assessment are viewed as case management functions few of the respondents were actually engaged in these activities.

There is wide range of service activities associated with the case management function. Respondents were asked to rate their perceptions of the appropriateness of specific service activities. Case managers raised concern regarding the appropriateness of the therapy/counselling and teaching/training tasks.

TABLE I

Service Activities Engaged in by Case Managers
(N=102)

Service Activities	Yes n	Yes %	No n	No %
a. Screening	45	44.1	57	55.8
b. Initial Diagnosis/ Assessment	47	46.0	55	53.9
c. Service Plan Development	91	89.2	11	10.8
d. Agency Contact	97	95.0	5	4.9
e. Client Contact	94	92.1	8	7.8
f. Recording/Reporting	87	85.2	15	14.7
g. Evaluation of Community Services	86	84.3	16	15.7

TABLE 2

Time Spent in Special Service Activities Per Week
N=102

Item	1-10 Hours n	1-10 Hours %	11-20 Hours n	11-20 Hours %	21-30 Hours n	21-30 Hours %	31-40 Hours n	31-40 Hours %	No Hours n	No Hours %
a. Screening	43	42.2	-	-	-	-	2	1.9	57	55.8
b. Initial Diagnosis/ Assessment	45	44.1	2	1.9	-	-	-	-	55	53.9
c. Service Plan Development	71	69.6	14	13.7	4	3.9	2	1.9	11	10.8
d. Agency Contact	69	67.6	26	25.5	-	-	2	1.9	5	4.9
e. Client Contact	70	68.6	17	16.6	6	5.9	1	.98	8	7.8
f. Recording/Reporting	70	68.6	15	14.7	2	1.9	-	-	15	14.7
g. Evaluation of Community Services	79	77.4	6	5.9	1	.98	-	-	16	15.7

ORGANIZATIONAL CONTEXT OF THE CASE MANAGER

A review of the data related to the work environment index indicates that the case managers perceive themselves to be under constant pressure. This was manifested by a 'sense of urgency' about everything, and a feeling that people 'could not afford to relax.' Despite perceived disorganization in the work environment, 70.2% indicated that there was strict emphasis on following policies and regulations. Trying out new ideas was acceptable in their place of employment (as reported by 40.5%) but subjects were evenly split on whether doing things a different way was valued.

The overall responses indicate that there is significant evidence of dissonance among case managers regarding their work environment. The case managers appear to operate in an environment in which they receive mixed messages. For example, the strict emphasis placed on policies and regulations does not necessarily conform to the notion that new and different ideas are always being tried. Because this part of the survey yielded such findings, an attempt was made to further analyze the data.

Additional insight was gained by the examination of specific factors associated with the work place which were rated by case managers. Responses indicated the importance of aspects related to case management functions as well as to personal needs of individuals.

In general, such factors were reported to be underrepresented in the actual work situation. That is, the case managers indicated that none of the factors rated as important existed in the work place to the extent that the subjects thought they should.

The survey results show that most case managers do have job descriptions. For the present research these descriptions were not examined to determine the degree of consistency, or lack thereof as it relates to tasks performed by case managers. Job descriptions were not examined across agencies and/or counties to ascertain the similarity of job definitions. The job description was assumed to provide a framework and therefore guidance to the individual in his/her performance of job.

Another dimension explored in the survey was related to success and effectiveness on the part of case managers in light of the problems in the service delivery system itself. Many supporters of deinstitutionalization take the position that the case manager is essential to the successful community of adjustment of mentally retarded individuals. One of their primary functions is linking the individual to the needed support service(s) and to do so successfully, there must exist a service system that is capable of meeting the needs of the client population. All case managers indicated that there were times when support services were unavailable, some being unavailable 100% of the time. Given such a finding, it would appear that the identification of resources/services, by default, becomes a necessary case management function. Success of case managers working with the deinstitutionalization process is dependent upon the ability to identify services which meet the needs of the clients. It is therefore not surprising that case managers are motivated to establish their own resource files.

Although case managers frequently find it necessary to rely on themselves, they do indicate that they seek out the help of others when appropriate services for their clients cannot be located. Most frequently, help is sought from their supervisor or other case managers. The least frequently relied upon sources of help are the State Office of Mental Retardation, executive director of the agency, and the regional office of mental retardation. Interestingly enough, such a pattern of help-seeking behavior on the part of case managers contributes to the problem of inadequate services. Problem solving with other case managers and immediate supervisors results in the higher administrative

bodies being insulated from the full impact of inadequacies in the service delivery system. In each case, the case manager usually tries to solve the problems associated with a lack of service on a case-by-case basis, hence no pressure is placed on that system to develop services which will systematically meet the needs of mentally retarded individuals. When this lack of service leads to the reinstitutionalization of a mentally retarded individual, the failure is viewed as personal rather than systemic. The case manager, in these instances, becomes the focal point within the system to whom criticism is often directed.

Another aspect of the organizational context of case managers is associated with authority and decision-making power. The majority of the case managers indicated that there was a discrepancy between what existed and what should exist as it related to authority. There was also general agreement among subjects that the sphere of influence held by the case manager was limited. However, case mangers are very involved in decisions regarding the purchase of services. Though these decisions are most frequently made in conjunction with others, this provides a source of leverage for case managers when dealing with service providers. This is especially true if a significant proportion of the service providers' clientele is represented by the case manager's agency.

Having a sense of empowerment is important in the case manager's perception of what he/she does, and influences the energy expended in carrying out tasks. And it is also important that efforts are valued by others. The majority of case managers do perceive themselves as being valued. However, it is unfortunate that almost 25% indicate that case management is not a service valued by their own or by other agencies. However, the support given to case managers for continuing education and training opportunities is some indication that they are valued by their own agencies.

Continuing education and training provide case managers with the opportunity to upgrade their level of knowledge and skills. As skills are enhanced, case managers may gain a greater sense of control and direction in the performance of the case management function. Increased knowledge and skills can foster innovative approaches to problem solving and enhance the confidence of those outside the organization in the competency of the case manager. As such, case managers could conceivably have more influence over policies, especially those directly related to client services. Case managers did indicate that training and educational opportunities were supported by their agencies. A number of case managers did however, qualify their responses indicating that while training was suggested in theory, the lack of funding or lack of release time limited the utilization of training opportunities. It is interesting to note that the minimum training is now required for all direct care staff who work in the residential programs in which mentally retarded persons live. Yet, those persons who have been identified as having primary responsibility for the planning and development of the individual habilitation plan are frequently left to pursue additional training on their own. The demands placed on the individual case manager are many. These demands relate not only to knowledge of the service system in the field of mental retardation and other ancilliary fields, but also to knowledge about mental retardation itself.

THE EDUCATIONAL AND TRAINING Neeed of the Case Manager

Another issue relevant to case management is the knowledge, skills, and abilities required in order to perform the necessary functions. The item receiving the highest rank by case managers was, "knowledge concerning the needs of the client group." However, it is not known if the case manager who is most knowledgeable in issues related to mental retardation is actually the most effective case manager.

Interestingly, the ability to analyze data was not perceived by case managers to be as important as some other skills. The case manager is often presented with technical and conflicting data from many different sources, is generally the single person in the system designated to provide access to and continuity of services, and often makes life decisions for mentally retarded persons. How then do they make these decisions? It would seem that having the ability to analyze data is extremely important to the case management process. Because this process involves the actual gathering and understanding of varying reports from support services which include specific types of data (e.g., psychological testing, visual and auditory data) it is imperative that case managers are able to integrate such information. The case manager must accurately and effectively formulate a "life plan" on behalf of the client based on this data. Thus, the importance of the skill to analyze and interpret data deserves further scrutiny

Another skill area which was perceived as relatively unimportant by respondents was that of clinical and therapeutic technique. Fewer than 50% of the case managers rated this skill as "high". Although many respondents defined aspects of case management by using terms such as "listening, being supportive and providing information," which are terms often related to clinical skills, their responses indicated that this skill area was not an important one in case management performance. There were no skill items delineated in this section which more than 10% of the case managers rated the item 1 or 2. This suggests that case managers generally find all of these knowledge and skills of some importance (though varying in degree) in the effective performance of case management.

DESCRIPTION OF THE CASE MANAGER

In the Southeast region of Pennsylvania, the average case manager is a white female, 31.7 years of age. Fewer than 20% of all case managers are of minority background. There are some questions raised regarding this situation: "Do minorities fail to be represented in this system due to lack of interest or are other factors determining this state? If so, what are these factors?"

One manifestation of the lack of participation of minorities in case management may be related to the interpretation of the Normalization Principle. For example, in planning for community residential programs, often little attention is given to where and with whom mentally retarded persons live. Such disregard for the prevailing norms of society may impact in a negative way on the success of mentally retarded persons. This is often manifested by community opposition to residential programs

being established in neighborhoods; further social interaction can be diminished as well as relationships of a closer nature. While it is not the belief of this researcher that all accepted norms can be identified as fair or equitable, they do provide the framework in which most individuals function. It would, therefore, appear that mentally retarded persons are thought of and planned for in ways that run counter to many existing norms. Establishing sets of behaviors that in fact make mentally retarded persons stand out from the majority is counter productive to the goals of deinstitutionalization.

Case management and its success have been associated with the level of educational background. Of particular interest is the fact that 35% (n-34) of the case managers have masters degrees. We see then, that a substantial portion of case management personnel are not without educational credentials. The problems associated with the case management may not be so much a function of the lack of ability or skills of the case managers, but rather may reflect problems within the system. Some of these problems include size of caseloads and lack of identified generic services to be used as resources.

Case managers on an average had spent 7-8 years employed in human services, and approximately the same amount of time in the field of mental retardation

The majority of case managers had majors in social work; the second most represented educational major was psychology.

From the findings, one cannot attribute problems directly to the training and educational background of case managers. If education is a major criterion, then the majority of the case managers meet the standard. Some questions may be raised about a field that employs primarily women and the way that this is generally reflected in terms of salary and status. One issue that is significant is the extent to which there is minority representation in the field.

DEFINITION OF CASE MANAGEMENT

What is case management? A simple question and yet one that has defied a consistent response. Despite the lack of consistency in definition, there exists within the service delivery system persons who are called case managers. These individuals are hired to perform case management tasks for which the parameters are frequently unclear. These perceptions of case management were delineated as the respondents attempted to define case management.

Case managers appear to have mixed perceptions of case management. The dilemma frequently revolves around the lack of precise definition and professional boundaries. Case management requires a facility for boundary straddling. How much should the case manager do? As one respondent indicated, "If the case management won't do it, who will?" Thus, one can see that for some case mangers their function and role takes on a moral and ethical perspective. The authority of the case manager rests primarily on those responsibilities which are linked to funding and eligibility. Not all case managers make such decisions; some must

present their cases to supervisors who in turn make the final decision.

A number of case managers used the terms "overseer" and "manager" to describe their roles. This is supported by the tasks most frequently listed in the definition of case management by the subjects. This would suggest that activities such as referrals, monitoring, coordinating, service plan development, and advocacy are those amenable to such a role perception. Another dominant view suggested that case managers were "doers" or "direct service providers." Tasks such as crisis intervention, finding services/resource identification, resource development, training, implementing programs, and counselling supported these perceptions. Clearly, case managers hold varying perceptions of just what case management actually is. This is reflected in the activities in which they are involved as well as their perceptions of the appropriateness of the case management tasks reported above.

In addition to mixed definitions of case management, case managers also indicated that there is a prevailing sense that what "others" expect of case managers is relatively inconsistent with their own practical experiences. This can perhaps be attributed to the lack of a clear, precise and an agreed upon definition of case management, i.e., the tasks for which these individuals are responsible, and outcomes for which they are held accountable. At the least, the absence of clarity of role definition as well as the lack of guidelines for the implementation of tasks can be the cause of dissonance among workers and reduced effectiveness of the case managment function.

It should be noted that this survey reflects a mix of case management models as well as perceptions of the case managers themselves. Further, it should be noted that 86% of the population of case managers responded to the survey. The findings, therefore, should be highly representative of the state of the art in case management in the Southeast region of Pennsylvania. Although there are a number of factors which have particular potency relative to case management in the region, the Pennhurst court-ordered deinstitutionalization is believed to have held special relevance for other case management systems throughout the country. This is particularly true in those areas being affected by court-ordered change especially as it impacts on existing service systems.

IMPLICATIONS FOR SOCIAL WORK

Case management has particular relevance for the profession of social work. It offers an opportunity for the trained social worker to utilize skills acquired through social work education in settings which serve the mentally retarded.

At a conference on case management in 1980, many participants suggested that the education and training provided social workers was the most appropriate for case managers. The present study showed that fifty percent of the respondents had a social work background, indicating that social workers do indeed represent the major pool of professionals engaged in case management activities in the Southeast Region of Pennsylvania. Case management, however, is not specifically

identified as a field of practice in the social work profession.

The training of the social worker tends to emphasize clinical and therapeutic skills. These are the very skills that have been de-emphasized in the case management function. The brokering and advocacy aspects of case management are not skills stressed in social casework education. The case manager is also expected to be capable of processing and integrating data from a variety of disciplines (e.g., psychology, audiology, and education) in order to effectively evaluate a client's needs. As the individual who is primarily responsible for the habilitation plan of the mentally retarded client, the case manager must be able to analyze and interpret data appropriately. These skills do not get enough attention in social work education. Thus, we find many trained social workers engaged in work activities that do not necessarily utilize skills which they have acquired through training, and conversely, are faced with expectations in skill areas in which they have not been trained.

A case manager in the field of mental retardation requires a myriad of skills. Though ofttimes equipped to engage in therapy with clients, they perceive this as relatively unimportant with this population. The case managers are expected to collate, analyze and interpret data, but are neither expert in these skills nor perceive them as important. It is possible that the ability to adequately deal with data is perceived as unimportant because of the lack of adequate training in this area. The inconsistencies between the training of social workers and those skills necessary in the field (particularly case management) warrants further scrutiny. As more and more people for example are deinstitutionalized, (not only in the field of mental retardation, but also, for example, juvenile justice, etc.) skills in case management will become increasingly important.

The role of the case manager should not be undervalued in the field of human services, particularly social work. Case management warrants further examination as a means of providing effective services to populations labelled at risk.

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